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| **EATING DISORDERS WORKSHOP,****Questions & Answers:****Provincial Specialized Eating Disorders Program** **BC Children's Hospital** |
| **Q: When refeeding with glucose, can you see thiamine deficiency or refeeding encephalopathy?** |
| **A: Dr. Pei-Yoong Lam, Adolescent Medicine Physician:** |
| I see Thiamine deficiency less frequently in kids and more in adults. There is a study of thiamine deficiency in kids with anorexia being done in Ottawa. I personally have not have seen that, because the diet tends to be rich in green, leafy vegetables. I have only ever seen refeeding encephalopathy once, in my entire 20 year career. And that was in the context of a kid who was given nasogastric feeds of 3,000 calories from day one. We are not saying start at 3,000, we are saying start at 12 00 or 1500 calories. Oral feeding tends to provoke less of that response than NG (nasogastric) feeding. |
| With regards to IV glucose, I find that a tricky situation to manage, because you can give them IV glucose and it bumps up their glucose level, but once you start to wean the glucose away, you may actually get rebound hypoglycemia, which is another manifestation of refeeding, and that can be quite dangerous. So if I don’t have to use an IV, I won't. I try to do everything orally. If I have to rehydrate, I try to rehydrate orally or with a nasogastric tube. And if I have to do it by IV, I will try to hydrate without intravenous glucose. I would use normal saline (plus or minus potassium if there are potassium issues). I would try to not use glucose if I can. If it is unavoidable, I will wean it very, very slowly and increase oral intake to compensate as much as possible. |
| **Q: In your slides you showed BCCH's five urgent admission criteria for eating disorders patients needing medical stabilization. Those five were:** * **<75% IBW**
* **HR <45/min**
* **BP drop >20mmHg**
* **Electrolyte derangement**
* **Cardiac abnormalities**

**Do all five of those criteria need to be present, or is any one of them sufficient for admission for medical stabilization?****A: Dr. Lam**Not all five need to be present, any one of those criteria is enough for urgent admission. |

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| **Q: Eating disorders cause complications in puberty for females. What about males?** |
| **A: Dr. Lam**That is a good question. There is not a lot of data on male anorexia. What is out there is that the main complications are to do with affecting the male growth spurt and causing height restriction. There has not been anybody who has gone out there and measured testicular volume in starvation. But from anecdotal experience, boys have a lower or very low testosterone level with starvation and that does affect their testicular volume. . Their testosterone levels go up with refeeding. Now it works for some boys if you tell them this, they are on board. But there are some boys who do not want to grow up, do not want to go through puberty. Whether they have issues with sexuality and gender, or issues with not wanting to grow up altogether, that approach does not work for these kids. So be careful about who you are giving that information to. But you are right there isn’t much out there. |
| **Q: High-performing kids with ED often want to return to school ASAP. When do you allow them to return to school?** |
| **A: Tom** **Bauslaugh, educator**The thing I always focus on is, the health comes first. If they are at a healthy weight and they are eating enough, then these other things are possible. If you are not doing those things then you can’t go back to school, you can’t be involved in those sort of things at school.  |
| **A: Karina O’Brien, psychologist** |
| I would talk to parents about that. Luckily at our assessments, our pediatricians, if they have concerns about anything health-wise, they are pretty prescriptive about saying, “You must not return to school.” Much of the time families follow through with that, not always of course. In terms of returning back to school, I will talk about things to look at. Of course, the number one most important thing is you need to be able to eat all your meals and complete them 100%. How can we do that and also have you be attending school? We’ll see if the family feel the child is ready to do that, or if they can think of some creative ways, like driving to school and having them each lunch in the car and then having them go back into school. And are they going to be able to continue to gain weight at an appropriate rate?. So not at 0.1 kilogram while in school. So they will need to be able to eat enough to sustain that level of activity.  |
| Lastly, the social aspect being at school. Is that going to add anxiety and stress for them? The academic side: what will it be like to have people commenting that they're back, deadlines, eating lunch with peers? We will have a conversation about it, and ultimately the decision is with the family. But in general, it is gradual, gradual. If a kid has been out of school for a month, they probably don’t want to go back to high school 5 days a week. So collaborating with the school around a gradual return to school.  |
| **A:Karen Dixon, social worker & family therapy** |
| Another thing that is important in going back to school, this is where communication, collaboration and interdisciplinary team work can be really handy. If the youth does go back to school, school personnel are able to keep an eye on them and see if there is any odd behaviours, clues.  |
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| **A: Dr. Lam** |
| I always advocate full disclosure to the school. I know that some families have trouble with that, but I always try to get them to make a full disclosure, because I think the school needs to know, particularly if you are taking the kids on a field trip or taking a kid camping. So I always advocate full disclosure with the school. |
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| **Q: How do you treat a kid with multiple stressors of which disordered eating is just one symptom**?  |
| **A:** **Dr. Lam** |
| I think you are describing a patient population where eating is one of the manifestation of their inability to regulate their emotions in their lives. I am choosing my words very carefully as I am trying to be consistent with DSM V. I find they are a very difficult population and they are not like our classic AN population that has acute starvation. These kids tend to have more of a mix of binge/purge. And then they may swing further down to the starvation mode later on, but then they swing back up again and it is very fluid.  |
| The way I conceptualize these kids, more that it is a manifestation of all the other stuff that is going on for them. It is a symptom, just like cutting, or suicidal ideation. Distorted body image is just another symptom and the way they deal with it, it is a manifestation of that symptom. They do not do well as inpatients because what we are doing as in-patients is taking away the ability of one of their coping mechanism, but not replacing them. We do try to keep them as outpatients and try and introduce DBT as soon as possible, because it is about emotion regulation.  |
| **Q: How do we raise awareness about eating disorders around BC?** |
| **A: Dr. Lam** This is a significant issue in BC, how can we raise awareness in the province and help educate professionals in the school setting, in the health setting and probably in the sport setting. I am going to get Rylee to answer that. |
| **A: Rylee McKinlay** |
| The work that we do with the South Okanagan/ Similkimeen Action Team, is more broadly about raising awareness of all mental health issues. And I think it is important for all aspects of mental health to get spoken about. Some of the initiatives that we started with are incorporating learning for teachers into Pro D Days. On Pro-D Days a doctor will come in and give the teachers an introduction to mental health, versus mental illness, these are the things that we look for. They are not getting intensive training in how to deal with these things, but just small steps and bringing about awareness so they have it on their radar. The people who don’t have mental illness or mental health issues in their life, in any aspect, it is not really only up to them. That is one initiative that we have been working on. We just had a speaker who talks about depression. He was just in the community. We had everybody from parents, teachers, kids. That was to start talking and get the conversation going. Again these initiatives are more based on *all* mental health. Just community based initiatives are the biggest things. Bringing in speakers, having parent education nights, based at the school or based out of here. People in the community who are interested in this need to start a conversation. We have to start talking about it. |
| **A:Terri MicKinlay** |
| After Rylee started to talk to her school, the school decided to take on some initiatives around mental health and they decided that it was to commit to teaching about health and wellness in mental health. They have done this in a lot of ways. They accumulated a library of books which the teacher had to read. They do a little mental health fair, all kinds of community support sharing what they do to support kids in the community and making those connections. The school has actually been really committed and benefited to making this their main purpose. We are very fortunate in that regard to make that connection.  |
| **Q: What sort of tests should you do for thyroid function?**  |
| **A: Dr. Lam** |
| One of the things that I did not present because there is so much information, is about the thyroid. When you are starved, your thyroid function is altered. If you do a T3, and T4, you will find that it is all a little bit suppressed. You may not get that necessarily with the TSH. Sometimes you can get a mild suppression of the TSH, but there is suppression of thyroid function. You may get a sick euthyroid picture rather than hypothyroid syndrome. Do the TSH and if you have any concerns get a T3 and T4 as well. |
| **Q: Are there any characteristic patterns of substance use that you would associate with eating disorders?** |
| **A: Dr. Lam** |
| We see a variety of substance use. Again, we have seen kids who have experimented with alcohol, usually vodka - zero calories. Not so much marijuana- that doesn’t work as it stimulates your appetite.. And methamphetamines. Certainly kids who have been previously diagnosed with ADHD, or ADD may abuse their stimulant medication.  |
| **Q: If you are not sure if it is an eating disorder, how can GPs or schools reliably screen for eating disorders?** |
| **A: Dr. Lam:** A very common screening tool that I recommend to GPs as well as pediatricians and even schools can use it, is the SCOFF questionnaire. It is free. It is 5 questions. You can download it from the internet. If there is a score of 3 or more, then that is a red flag for more questioning. I didn’t put it up there because I thought it was too much. But if anybody wants it, I’m happy to email it out to them. It basically says, ‘have you ever made yourself feel sick? Do you feel out of control with your eating? Do you worry about your body too much? Have you lost more than X pounds?’ I think just introducing a simple screen for kids that you have an inkling about may avoid some of that, may help you set the scene, sooner, rather than later. |
| **Q: What do you do if parents are not supporting the treatment or are trying to substitute their own food?** |
| **A: Judy Lirenman**That is the reason we have our meal guidelines. That is the reason why we have those pre-printed forms, and protocols, so that if the kid lands in the emergency department, that these are the expectations that are already set up, before they even set foot on the unit. That reduces a lot of angst because the parent is already being told, ‘this is what it is going to look like.’ And they’ll fight it, you’re right. Some of the parents are not ready to accept that diagnosis and they will say, ‘I don’t want to do this.’ Or if they don’t fight it, they’re basically being guilted into it by the kid. Very often a kid will go, ‘ Mom, I’ll eat it but you just have to bring that bread or yogurt from home that you bought for me.’ And the parent will come in with this yogurt and just ask to swap it. But it has zero fat, zero everything.  |
| You need a system in place that is already set, you can firmly and kindly say, ‘sorry but right now she is very unwell.’ We need to be 100% sure of what is going in and out. And that is why we need to control the food so rigidly because we need to know what is going in and out because we are monitoring their blood work, we need to be 100% sure that she is getting exactly what she needs. Most parents — I would say most parents but not all parents, because there is still an unreasonable core — most parents will then back down. But there are some parents, who don’t buy into the diagnosis, are looking for an alternative diagnosis, or just aren’t able to be there to provide them the support (for reasons of their own). In those situations I’ve said to nurses on the medical unit – they’re not meal support trained either, they don’t do meal support – so I say to them, ‘you have a conversation with the parent, realistically, what do you think you can do or are going to do?’ |
| **Q: In our hospital, we can't do one on one nursing. How can we supervise an eating disorder patient on the ward?**  |
| **A: Dr. Lam**On our acute medical unit, one nurse looking after an eating disorder patient does not care for just that one patient. She’s got other patients and other responsibilities. They have to balance those competing requirements as well. If the parent is not able to be there, then the nurse brings in the tray into the room, they know what’s on the tray, set it down and say a couple of encouraging things to the kid and then they come back in 15 or 20 minutes, and then come in and say, ‘how’s it going,’ etc. The decision has to be made later on about, whether we go to the NG tube feeding route, etc. Some hospitals have staff that will sit down and do meal support, that is great. Ideally I would love to see that happen in every hospital. But I’m also realistic, I know it can’t happen. It is not even happening at BC Children’s, so how can it happen where you guys are? We need to have alternatives that work for you. You need to find a structure that works for you. |
| **Q: How do you connect with a shy child or a child that won't talk?** |
| **A: Karina O’Brien, psychologist** |
| Actually, that rarely happens to me. The only context I would have would be sometimes I start FBT with kids with families while they are on a medical ward. You are talking about a child with anorexia, in that situation? I would be just be really casual, hang out with them, in the room with them. It is great if you can have the parents there, everybody talks together, so there is not all this pressure on the kids. Often those shy quiet kids with be listening when you’re talking to their parents. So kind of engage the parents, and if you notice the kid is smiling say, ‘oh your smiling when we talk about\_\_\_\_, is that something you like to do?’ That would be my first step. It is such a short term thing. I would be thinking intervention, change work, engagement work. Play games with them, if there’s not a parent there. Like a non-verbal card games of sorts. And try to chat with the child a little bit while you're doing that. |
| **A:Tom Bauslaugh** |
| If you think about how we engage with them in the first couple days, when your looking for answers. I think sometimes people go in to assess and talk to the kids, and for kids that are not necessarily talkative, if you are around, come in and chat with the parents, hang out and listen. Give them a sense that you are an okay person and not telling them what to do.  |
| **A: Karen Dixon** |
| I use silly-putty. I have lots of silly-putty in my office and that’s the starting point for my relationship with kids. So yeah, it’s not about their therapy, it’s all about the relationship. You just have to think about how long the relationship is likely to be. Engage from there.  |
| **Q: What do you say if a family asks if they caused the eating disorders, especially if there is dysfunction in the family?.** |
| **A: Karina O’Brien** |
| It is true that some people, some families when their already is an eating disorder may not be the best functioning families. It is also true that some families, where the child doesn’t have an eating disorder, are not well functioning families, so correlation isn’t an implied causation. We can’t say that because this child has an eating disorder, that has caused that dysfunctional family. And we can't say because this family had a dysfunction, that caused the ED. All the research shows us there some theories about why eating orders are caused, but they are quite complex and multi factorial. You could say that. That the cause of the eating disorder seems to be complex, multi-factoral and we don’t know exactly what combination of factors led to the eating disorder in this case. |
| **A:Tom Bauslaugh** |
| I wouldn’t look at it as "what causes it." I would look at now what do we do to fix this ED. And so all those dysfunctional things that you are seeing in the family are probably getting in the way of fixing it. We don’t know where it came from, but what is going to help is if we organize this, we get some therapy. It is probably going to be hard to do those things if there is addiction involved, for example. So probably the biggest thing is to solve some of the family things that get in the way of success, to cover off some of family things. Rather than being the cause, which is blame, frame it as being part of the solution |

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| **Q:How do you do a weigh in with a patient in FBT?** |
| **A: Karina O'Brien**,The pediatrician gets the medical weight — that is a different process. They would do that in a gown, they have a procedure for doing it. In Family-based therapy we don’t have the patient undress completely and be in a gown. That is not my role. So we do it in our comfort zone. So yes, shoes come off, because you want to get as accurate as possible. If it is wintertime, and they are wearing sweaters and coats, I think I would have them strip down to the tank top that they are wearing underneath their sweater. And if they have that really heavy belt on, why don’t we zip that off. Ask, “If there is a phone in the pocket, take it out of the pocket”, but basically light street clothes. We have a lot of kids that go to private schools and they wear heavy kilts, it would be nice to know how much those kilts weigh, it is substantial.  |
| Each time, we are weighing on the *same* scale, that is really important. The weight scales can be slightly different. You are looking at the difference from two week rather than comparison to a medical weight. In terms of your own attitude while you are doing it, just really, ‘matter of fact.’ This is how you do it. ‘Hi, how is it going. Over there on the sale, your weight was up by X pounds, what is that like for you?’ Then we will sit down and talk about it. Keep it very matter of fact, light, curious, ‘oh it went down a little bit this week, I wonder what some reasons for that were?’ It is pretty rare that we have major drama around that. Within the context that I’m doing it in FBT that would be extremely rare. Sometimes the parents get really nervous about it, ‘oh will you show her the weights?’ It provides exposure to what their weight is, and many of the therapy supported treatments for eating disorders involve the person knowing their weight and having exposure to that, including the CBT as well. If at all possible it is great. Do it, be open about it, be matter of fact, very transparent and then you are off to the races. Is it like an absolutely 100% the person will always know it, no, nothing is every 100%. |
| Sometimes, now and then, a kid can be cheating on their weight. Hiding something somewhere. Drinking a lot of fluids and then peeing it out later. If I have any worries about it I will ask the pediatrician when she sees them, “hey, do you mind doing a gown weight with So-and-So?” So we can just double check. Whether they peed, or they’ve emptied out their pockets.  |
| **Q: What advice can you give for starting a parent support group? Is it a good idea?**  |
| **A:Karen Dixon**:We have gotten feedback from parents who have gone to the parents support group. It has been one of the most powerful, supportive, things in terms of shaping how they think and shaping how they interact with their kids. It is an incredibly powerful tool. Highly recommend it. |
| **Q: What do you do at the parent support groups?** |
| **A: Karen Dixon**On occasions, we have invited guest speakers to come. And we have had specialists come and talk about medical consequences. We had a parent whose child had recovered, come to speak. And Tom and I are working at a forum of psycho education where we will bring a topic that we introduce in our therapy group for youth, we bring that same topic to the parent group. When we get consent from all the kids to share what they say – not identifying who said what, but what they say – We will bring that to the parents as well. And the parents are mesmerized. Because they hear the inner working of the kids' minds.  |
| When we started the group, we advertised it well and had a pretty good turnout. We worked with the parents in that beginning time to establish some norms and rules. Our attendance has really fluctuated, but I think marketing the group is really important. I think if there is acceptance in the community it would be better attended actually, you have a captive audience, but they have competing obligations. These parents and the programs we offer children are quite intensive, so it is one more thing for them. I think for the community it would be a great opportunity. |
| **A:Tom Bauslaugh,**  |
| We also had once a week that parents could call in. We have a call in phase. We even started with Psych Education, but most of the time it has just been parents coming together. We don’t really have much of an agenda. Sometimes we will have some ideas about some things to talk about, but that rarely happens. Parents just talking with each other is really good. |
| **Q: As a school counsellor, if I suspect an eating disorder, when in terms of confidentiality do I tell a youth, "I have to tell your parents"?** |
| **A:Tom Bauslaugh** |
| It is similar to anything else that is a life threatening situation. You need to report. I think if there’s not a confidentiality issue then I would really recommend getting parents involved. It’s not something you can trust youth with ED to make good healthy decisions for themselves, so I think it’s a real danger to try and work with that youth without the rest of the system working for you. Because it (the eating disorder) with lie, and cheat, and hide. |
| **Q:** **As a highschool counsellor kids with anxiety and depression come to talk to me all the time, but not the ED kids. How can I get kids with eating disorders to come to talk to me?** |
| **A: Karina O’Brien** |
| Eating disorders aren’t the same as anxiety and depression, where people are uncomfortable with the symptoms and will self refer. Many times the symptoms of an eating disorder are ego-syntonic. They fit with how the person feels or their identity, they think, “this is okay, I don’t want to change this.” So you may not have kids come and talk with you about it as a problem because they’re not distressed by it. So for you to feel guilty about not doing something is kind of the nature of the problem. You could try though. It would just be asking directly about symptoms and sometimes people will tell you. You just have to ask them directly about it.  |
| **Q: What do you do if the youth is in denial and not receptive to help?** |
| **A: Karina O’Brien** |
| Is there a point where the youth becomes receptive to treatment? From my lens which you heard a little bit about earlier, I’m really focused on the parents. My assumption is that the youth does not want to recover. Sometimes they do, and that makes treatment way, way easier. But if they don’t, and that is very often, that is okay. We are working on the parents. If you phone the parents and they are in denial, that is the point where you want to focus your intervention because they are the most important people in that child’s life. If you thought the child had leukemia, and it was undiagnosed and the kid was having nosebleeds at school every day and you phoned the parent and you say ‘I think your kid has leukemia,’ and they say, ‘no, I don’t think so, she just gets nosebleeds,’ you would say, ‘No you need to take her to the doctor. You need to go!’ So you need to think about it like this. Like leukemia. This is a medical emergency. I think we need to think about it that way, and help the parents take action. Part of the illness is the kid doesn’t get that it is an emergency and that is okay. They don’t have to get it. I don’t know if there is a point in treatment where that clicks on. A lot of the times it happens during the re-feeding process. But you have to start treatment before it clicks on. People that are starved don’t think that. |
| **Q:What do you do if the parents don't seem to understand how serious the eating disorder is?** |
| **A: Karen Dixon, MSW, family therapy** |
| I think parents, first of all, they *don’t* understand, I think a lot of parents don’t understand the full list of what an eating disorder entails. So educating them will help for that light bulb to go on. The second thing that I want to say, is that kids hide this stuff from them. They’ll make excuses about eating that sound reasonable. They will change how they dress to hide their bodies. There is a whole host of strategies that the eating disorder will engage to protect the knowledge that something is really wrong. Parents can feel a ton of shame that it wasn’t caught. But I say to parents, ‘well how could you have known? You genuinely didn’t see. When the picture is painted to the parents about what is going on with their child, they are horrified. Some parents, once in a while, they will not get it, even after that because of their own fitness when they were a kid, or their own body image, ‘The family has always been small this way.’ And those families are challenging in terms of helping them to understand, and helping the kid to move forward. |
| **Q: Your described very intensive involvement of the family during the recovery. Some parents, even if they want to be involved, taking time off work for 2 to 3 months while the child recovers is not a reality. What do you do then?** |
| **A:Karen Dixon** |
| Sometimes they either don’t want to, or don’t seem to be able too, or can't simply get there. There are agencies that help support parents travelling to a place like Children’s Hospital, if that is where the main treatment exists. That reduces some of those barriers. And probably the second thing that helps is the language that you use when you are talking to the parents. I go back to Karina’s example of a child with leukemia, do you think there would be any question about parental involvement if the diagnosis were leukemia? |
| **Q**: **How does treatment at BCCH work for somebody who doesn’t live on the coast?** |
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| **A: Karen Dixon:**We have subsidized accommodation. The BC residence program and the Ronald McDonald program offer housing for parents for up to I think 30 days, and then you go back, and come back again for another 30 days. That service is available. Very often parents will live with parents or other family who are in town. I know if you are with the RCMP or with the military, there is a lovely house in Surrey that you can stay in – but you’d have to have your car and commute. There are options about accommodations and we do have people doing the day program who live in Vancouver, Monday to Friday, go home on the weekends. One parent has to be down with the kids. |
| **Q**: **Are modern cultural expectations and social media fuelling eating disorders or have they been around a long time?**  |
| **A: Karen Dixon**Eating disorders have been around a long time. The earliest medical descriptions and the name was give by Sir William Gull, physician to Queen Victoria in the UK, in the early 1800s actually. He described three young women. That is the first medical description of anorexia nervosa. And there is a couple references in the Bible too. They are not a new concept. In terms of the impact of social media, etc., I think there is more awareness of it than there was before, just in the community.  |
| **A**:**Judy Lirenman** |
| I don’t know if it is occurring more often, or we if we are just more aware of it, and so it’s being diagnosed more often. And I would lean toward that.  |
| **A:Cathy DeCosse** |
| When I first started working with youth – and I worked on a medical floor with eating disorder patients, it was a medical illness – I guess it was still being hidden. So when people went home, they’d say, ‘oh my daughter had a medical illness,’ ‘ they had cardiac problems,’ whatever. So it was able to be kept a secret. But now, since 2000 I believe, we have them in as the mental health building and as part of the psych. There is more awareness around mental health anyways.  |
| **A:Dr. Lam** |
| People have studied that, the role of media, the role of culture, images, photoshop. They have looked at that, and definitely influences that way in the literature, but if you look at the BC Adolescent Health Survey, the percentage of kids who are under weight and reported as being underweight is fairly consistent. It is about 2 or 3%. It has been steady for the last 10 years or so. |
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| **Q: When might you put the youth on a mood stabilizer or an SSRI?** |
| **Dr. Lam** |
| This is a really great question. I’m very fortunate to work with 4 psychiatrists. In the days when I had no access to psychiatry, I would be the one who puts the youth on medication prescriptions. In current literature, there is no evidence currently that using an SSRI changes the treatment course of an eating disorder. There is no evidence that an SSRI helps with eating disorder thoughts, or changes in the kids' brain, or treats their eating disorder. The evidence suggests that using SSRI’s should be in the context of co-morbid depression or co-morbid anxiety. And even then, we choose *not* to prescribe an SSRI when the kid is very underweight. We wait until they are about 85% or more of their ideal weight, and if they are depressed and suffer from anxiety symptoms that don’t go away at that point, then we strongly consider using SSRI. My psychiatry colleagues tell me that because they are malnourished, there are not enough dopamine receptors for the medication to work properly. So if it’s prescribed too early, it does not provide the effect it should and the kid will become disillusioned and say ‘all medication’s don’t work.’  |
| The other class of medications that we sometimes use in kids that are under weight are the 2nd generation anti-psychotic medication. Again, there is very little evidence that it changes eating disorder thoughts, it definitely does not cure the eating disorder. There is a side effect of weight gain, which is very commonly searchable on Google. As this is highly visible as a prominent side effect, most of them will refuse it. The one that we tend to use is quetiapine as it has the least side effect of weight gain. Even then, if you look at all the 2nd generation anti-psychotics, the literature suggests that they don’t cause weight gain in our population. They cause weight gain in the schizophrenia population, the psychosis population, the bi-polar population, but not in our population group. I think that the eating disorder drive is so strong that it counters that side effect t. We use quetiapine in particular, to help kids sleep at night and also to immediately reduce anxiety. Sometimes when they become very aggressive, when they become very agitated -- so much so they can't even sit at the table, or sit down -- we are inclined to use it But I would use it in lower doses, more for its sedating properties than the higher doses for its antipsychotic purpose. |
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| **Q: Does anxiety always underlie eating disorders?** |
| **A: Dr. Lam** |
| What we do see is a lot of co-morbid social anxiety or generalized anxiety, or in some cases obsessive-compulsive disorder. If you are underweight, it is hard to screen for the anxiety, but when you ask, you can separate it out. A lot of the anxiety in an eating disorder/malnutrition-induced situation will be around food, exercise, how they look, the clothes they wear. But if this anxiety is not related to that, then it is highly likely that there was a co-morbidity anxiety, either pre-existing or existing side-by-side with the illness. In that situation, I’d still see the kid first, and get their weight up, get their brain working and then think about using CBT or SSRI + CBT.  |
| **Q: Are there other kinds of eating disorders that are becoming more recognized?** |
| **A :Dr. Lam** |
| Yes. There is a category in the DSM V that I think a lot of pediatricians would see, called Avoided, Restrictive, Reduced Feeding Intake Disorder, ARFID. It is actually an eating disorder that is present in an adolescent or a child that is so severe that nutritional supplements or tube feeding or NG feeding is required. It significantly impacts their lifestyle and everyday function. But without fear of weight gain and without body image distortion. The trigger point would be an anxiety or phobia around vomiting or around allergy or around an illness like rheumatoid arthritis. There is still the unspecified feeding and eating disorder, which is U-FED in the DSM V. I think the approach to both ARFED and UFED are pretty much the same. I would suggest a very family based approach, the parents take charge of the refeeding, you still need to feed the kids, no matter what the diagnosis is, and then we’ll work through it. |
| **Q: Can kids with anorexia become overeaters and start eating too much?** |
| **A: Judy Lirenman** |
| It is not uncommon for someone with anorexia to go to the other side and binge. We often see that. It is on a pendulum. We don’t typically see it on an inpatient setting. Whether you have an eating disorder or not, any period or restriction is going to lead to over eating. Sometimes just by the nature of their meal plan, that is enough over eating for them, but for others it is not. That is something, in terms of that maintenance phase, sometimes that is one of the other struggles that people have. They get these really, really intensive hunger cues and they really want to over eat. We work out ways of giving them permission to eat more. And allowing them to be okay with being at the higher end of the range for a period of time. And then it tends to settle out.  |
| **A:Dr. Lam** |
| I find that the kids who move that way are the kids that have had that history of overeating before or being a bit out of control with their eating before they got ill with anorexia. So I know to look out for that when it comes to their recovery. Then they can move into this binge eating/purging. They just hate how their body looks. There is often a bit of that see-saw happening, and then they start settling. But it might take years.   |
| **Q**: **Can you speak more about a genetic predisposition for eating disorders?**  |
| **A:** **Dr. Lam** |
| There has been some research on epi-genetics and genetics, looking at the incidents in eating disorders in clinic studies, in families, etc. Sadly, unlike schizophrenias -- there are some gene sections found for schizophrenias -- there really hasn’t been any promising findings in anorexia and eating disorders. Partly because the numbers, tiny. You can’t make clear conclusions from that. There isn’t like, ‘on this half of this chromosome, if you have that variation, then you have an eating disorder.’ But very often I find that when I go back, getting the family history, someone will say, ‘Grandma was weird with her eating. And mom had some sort of eating disorder that she never told anybody. She just got over it herself.’  |
| In terms of the genetic predisposition, if a kid or parent said to you, ‘why did I develop this eating disorder, how would you answer that question?’ My response was that, ‘well honestly I would say it is not a choice.’ It isn’t helpful to say that it is your fault, or that it is anybody’s fault. I don’t find fault,. There is no relationship to what I do with the kid, with the treatment. I usually say that sometimes there is a bit of a history of it, plus the temperament of the kid predisposes them of going down that path, plus the perfect storm of stresses in life. Being bullied at school, having that expectation of performance. All these sorts of things can add up to a perfect storm for someone who has that type of temperament and inspires them down a particular rabbit hole. When they start, it becomes their default mechanism for handling any kind of stress. |
| **Q: Is the egodystonic nature of anorexia part of the brain disorder, or did it result as part of the starvation process?** |
| **A:Dr. Lam** |
| Well that is chicken and egg. I don’t know. There is a lot of new imaging studies that are being done in the UK and US, with FMRI imaging looking at families with a history of eating disorders, looking at the particular changes in the brain when you have an eating disorder, when you are recovered. I think the literature is saying that even when you are recovered, there are still some abnormalities in how your neural networks connect, that kind of predispose you to it, but nobody has been brave enough to stand up and say, ‘Let’s screen everybody. And these people with these neuro-connectivities, will develop an ED.' I don’t think we are that point where we can say that yet.  |
| **Q: When do you use the Mental Health Act to commit a child into hospital with an eating disorder?** |
| **A: Dr. Lam**That is a question I get a lot from GPs and pediatricians. And I have to say that I have become more liberal in using the Mental Health Act because of my recognition if how serious it is. A kid that comes in with a heart rate of 38 and you can't get a blood pressure, and the mom is in denial...I have no hesitation. She needs urgent medical resuscitation and it is not an option. I will use it when there are clear indications -- that the kid is medically unstable.... So I would certify that kid to get them into hospital. I think the challenge then is getting someone to uphold the certification. When you have clear grounds for a medical admission you need to find a second physician or a psychiatrist to uphold the certification or acute mental illness certification.  |
| **Q: What shouldn't you say to a kid with an eating disorder?** |
| **A: Dr. Lam:** |
| The classic one, after a kid has been discharged from hospital is that ‘you look so much healthier.’ To the kid that translates to: ‘I’m fat.’ Healthy equals fat, so don’t say that. I think generally, just avoid all comments about appearance. Don’t even go there. |
| **A: Tom Bauslaugh** |
| Don't give them a target weight or really concrete advice. Something that we run into a fair bit, when other people’s advice is used to prevent eating in our situation. The kid will say to us: ‘But the doctor said that I need to be here,’ or at XXkgs" or whatever. So avoid a number if you can. When we talk about numbers, when kids come into the hospital, be cautious around any kind of definitive resolution you can give. ‘The doctor 2 years ago said that I need to do this, and not do that.’  |
| **A: Karen Dixon**Don’t lie to the kid. I don’t know if it’s something doctors have done, but I know it is definitely something the parents have done. Saying, ‘well you have to go to Children's, Hospital, but it’ll only be a week or two.’ We run into that all the time. And it may only be a week or two but we don’t know. There’s a lot of undoing around those promises. I appreciate that they are desperate — they are trying to get the kid here. They want to use any measure they have at their disposal – bargaining, negotiating, cheating, lying, etc – but it’s really challenging to work with a kid who’s determined to walk out the door after two weeks.  |
| **A: Karina O'Brien** |
| It might not be in the top ten but it’s definitely a pet peeve of my own, when a physician says to a family, when the child is at 68% of their standard body weight: ‘I’m so concerned about your child’s depression I think she really does need go back to playing basketball and going to her basketball tournament, because her mood trumps the eating disorder.’ That really burns me.  |
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